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ABSTRACT

Research has explored the relationships between older adults in need of help and the informal support systems of caregivers. A preliminary analysis was conducted to examine all major facets of gerontological caregiving relationships and to differentiate findings in each area by the sex of the caregiver. Subjects were 121 informal caregivers of elderly relatives who were clients of the Loretto Geriatric Center of Central New York. Subjects completed questionnaires about their thoughts, feelings, and actions relevant to caregiving and their relationships to the care receivers. The results revealed that 79% of the caregivers were women. The overwhelming majority were family members, 45% of whom were adult daughters, 11% adult sons, and 11% adult siblings. Most respondents reported positive feelings about the caregiving relationship. Some sex differences were revealed: more women than men reported resentment toward non-helping relatives; more women than men felt their own health had suffered; and more men than women felt they did not do enough for the care received. These results say much about sex roles in American society and suggest implications with respect to social policy and the formal versus informal support systems of the elderly. A two-page reference list concludes the document. (NB)

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CONTRIBUTIONS TO SUCCESSFUL AGING BY FAMILIAL CARETAKERS AS DIFFERENTIATED BY SEX OF CARETAKERS: SOCIAL POLICY IMPLICATIONS

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Statement of Problem

Since the late 1970's, important pieces of empirical research have explored the relationships between the older person in need of help and the informal support systems of caretakers (e.g., Seabach and Sauer, 1977; Treas, 1977; Lee, 1979; Frankfather, 1981). The issues explored have included identification of the caretaker's relationship to the older person, types of services provided, types of services requested or demanded and the attitudes of the caretaker. At least one major work deals explicitly with gender differences in the caretaker role, but this research limits itself to the issue of filial expectations for responsibility (Seelbach, 1977). Research reported in this paper explores all major facets of gerontological caretaking relationships and differentiates findings in each area by the sex of the caretaker.

Methods

Loretto Geriatric Center of Central New York offers a comprehensive array of services varying from day treatment to skilled nursing institutionalization. Families or close friends of the residents of Loretto received questionnaires requesting information about their thoughts, feelings and actions relevant to caretaking and their relationships to the elderly residents. In each household, the primary informal caretaker was asked to respond. Twenty-five percent of all families of Loretto clients responded (N=121). They represented clients from all levels of care. The sample was representative of the total population of clients also in terms of sex ratio (80% female) and age range (64 to 101, median=84), and there were no obvious biases in the sample definable in terms of other basic demographic statistics. Only 2% of the caretakers live with the elderly clients.

The preliminary analysis, partially reported herein, provides frequency distribution information on each variable in the study and cross-classifies these descriptive statistics by sex of caretaker. In this sample, percentage differences between the sexes needed to exceed about 25% in order to achieve statistical significance by Chi-square at the .05 level or better. Because the social workers involved in the study perceived differences of 10% or greater as meaningful for policy and practice purposes, both statistically and substantively significant gender differences are reported in this paper.

Results

Of all significant others providing care to Loretto's elderly, a great proportion, 79%, are women. The overwhelming majority are family members, 45% of whom are adult daughters and 11% adult sons. As many siblings provide care as do sons. The ages of the caretakers range from 30 to 90 (median=58). The older people they helped needed help largely because of physical limitations (59%) and, secondarily, because of mental limitations (23%).

Different types of services were provided by the caretakers when needs for services were indicated. Overwhelmingly, caretakers were willing to give of their time (94%). Seventy percent visited the older person frequently, 66% helped them take care of finances and 53% provided transportation. By means of these, and other ways of relating, 87% provided what they described as emotional support. Differences among male and female caretakers were apparent in only two of the above areas: women were more likely than men to offer emotional support (88% versus 81%) and visit frequently (74% versus 54%).

Although willing to help older persons manage finances, only 26% of caretakers would or could provide direct financial support, when a need was so indicated. Few provided needed meals (20%) or help with housekeeping and personal care (28% and 29%, respectively). Patterns of differentiation by sex of caretaker indicate a greater tendency for women than men to provide meals (19% versus 8%), but a greater tendency for men than women to provide help with heavy household chores (38% versus 24%).

A great majority of the caretakers feel good about their roles. Ninety-two percent said they believe they contribute to the well-being of the older person and 77% expressed pleasure with their relationship. Fifty-nine percent want to give more of their time. These findings do not vary by sex of caretaker.

Correspondingly, the complaints of caretakers are few. Nevertheless, problems exist. Forty-seven percent of the caretakers feel stressed by the demands made of them and 40% feel some resentment toward the older person. Resentment is felt also by 27% for relatives who do not help. About 20% claim that their health, personal time, social life and family life suffer because of their care giving.

These findings are differentiated by sex of caretaker most notably in the level of resentment reported by women against non-helping relatives: 30% of the women versus 14% of the men feel such resentment. Correspondingly, women are more likely than men to report that their health has

suffered (19% versus 7%). It is male caretakers who feel they do not enough for the older person (55% of men versus 39% of women).

Discussion

Two perspectives are utilized in the analysis of these results. First, what do they say about sex roles in this society, particularly with respect to the provision of care for older individuals? Second, what implications may be drawn with respect to the formal vs. informal support systems of the elderly? These perspectives may provide insight into the very personal issues of a family's ability to cope with the needs of an older member as well as providing direction for planners and policy makers.

Who Provides Care?

We have reported that, of all significant others providing care to Loretto's elderly, the great majority are women, and the overwhelming majority are family members. These results are consistent with the preponderance of literature in this area. That women take on caregiving roles more that men do seems to confirm the traditional stereotype of women as nurturers. The other result, that caregivers are family members, lends support to the refutation of the conventional myth that families have abandoned their older members to the care of formal service systems. After a brief overview of the literature in each of these areas, some possible interrelationships of these results with other findings of this study will be suggested.

As stated, recent literature overwhelmingly supports the finding that women, particularly adult daughters, continue to be the primary providers of care to older persons; feminism, and the entry of significant numbers of women into the paid labor force notwithstanding. Elaine Brody (1981; 1983) reports that, despite more egalitarian attitudes with respect to caring for older family members, women continue to provide that care. "It cannot be assumed that the women's (or men's) opinions about the sharing of responsibility by husbands and brothers are now, or will in the future be, translated into actions. Women themselves, with deeply internalized social strictures and ingrained behaviors, do not always demand that men share" (Brody, E., 1981: 476). Similarly: Johnson (1978) reports that older women count on support from their adult daughters in a way not paralled in other parent-child pairs; Robinson (1979) suggests that women feel a greater responsibility, due to differential socialization, for helping parents than do men;

Gray (1980) reports that women develop a greater attachment to their parents than do men, and that this attachment is not correlated with a woman's employment status; Nelson (1982) suggests that society has accepted the notion that sons are not responsible for the care of their parents; while Tobin (1981) concludes that daughters are expected to assume responsibility for their mothers and elderly women for their husbands; Hook (1982) found an over-representation of women in his sample of nursing home visitors; and Archbold (1983) concludes that, in general, women assume parentcaring responsibilities with little social and economic support.

Likewise does the literature show a high degree of consistency with the finding that families continue to be a major source of support for elderly individuals (Shanas, 1979), and that the traditional value of family care of the elderly has not eroded (Brody, E., 1983). Results reported by Weeks (1981), Tobin (1981), Smith (1979), and others support this finding.

Sex Differences in Caregiving Patterns

The Loretto findings indicate that, in general, positive feelings about the caregiving relationship are reported. Men who provide care express similar feelings about that relationship as do their female counterparts. It must be considered that, because the sample is comprised of voluntary respondents, this (and other) result may be effected. It may be that people who are feeling less positive about their caregiving role are not willing to share their feelings, due to guilt or other inhibitions. Or, they may view a questionnaire as just one more burden in an already burdensome relationship. Furthermore, the fact that only 2% pf responding caretakers live with the elderly individual may indicate that there is already a sharing of responsibility between the formal and informal service systems, which may be a large contributor to the generally positive feelings reported.

Given the sex differences noted in other areas, this finding, that general attitudes about the caregiving role do not vary by sex, may seem, at first glance, to be inconsistent. Several factors, however, may be at work. Robinson (1979) reports that stress with caretaking roles is more closely correlated with infringement on the caretaker's lifestyle than with the degree of impairment of the person in need of care. Given that these respondents do not live with the person for whom they care, it may be that the sex of the caretaker is less important that the absence of full-time responsibility. Another factor may be that women expect to do more, and, therefore, despite the findings that

they are more apt to let their own health suffer, and feel resentment against non-helping relatives, report the same generally positive feelings as do men. In-depth, qualitative follow-up with these respondents might yield indights into these issues.

Sex differences were found in the helping functions provided by men and women. Women were more likely to make frequent visits, prepare meals, and provide emotional support. Men, on the other hand, were more likely to help with heavy household chores. These results, again, are consistent with other results reported in the literature and with traditional sex roles. Hook (1982) found that daughters were more likely to make daily or semi-weekly visits than were men, while Nelson (1982) asserts that women are socialized to assume nurturing roles (like providing emotional support) while men are socialized into instrumental roles (e.g. heavy chores).

Women were more likely to report feeling resentment against non-helping relatives. Similarly, Archbold (1983) reports that sibling conflicts grow from perceived inequalities in parentcaring. By virtue of the fact that so many more women that men provide care, it seems likely that they are more apt to be in a position to have non-helping relatives than are men. It may also be, given the apparently strong influence of societal expectation upon women to fulfill caregiving roles, that men are more likely to fill those roles when there is not an "appropriate" woman to do so. If the case, it could mean that men are not as likely to have non-helping relatives to resent. Another, more subtle, dynamic may grow from these patterns of socialization. It may be that women, provide care to elderly relatives, at least in part, in fulfillment of role expectations. A reluiting perception of lack of choice combined with the relatively fewer accolades which usually accompany the accomplishment of expected (as opposed to non-traditional) roles may provide a situation which fosters resentment. Men, however, may be more free to choose caregiving roles, and may receive more positive reinforcement for doing so. This element of free choice may be one the deserves more investigation by social planners and researchers interested in fostering good quality interactions between elderly individuals and their families.

Women are more likely to report that their own health has suffered as a result of their caregiving role than are men. This may reflect and/or support the notion that women provide care because of clear expectations placed upon them, even if this places their own health in jeopardy. Whereas, a man in a similar position (e.g. that care providing functions would be detrimental to his own health) might feel freer to opt out of that role. Other factors contributing to this result may grow from the different caregiving

functions performed by men and women. Women were more apt to make frequent visits than were men. Zarit (1980) found that feelings of burden are more closely correlated with frequency of visitation, not the impairment of the older person. Such feelings of burden may become reflected in poorer health, especially among a group who are expected to be nurturant. Also, if women are filling nurturing, and men instrumental, roles, it may be that the day-to-day psychological stresses of an emotionally supportive role has more impact on a caregiver's health than does an instrumental role.

The men in this study, who are already providing care, reported more frequently than did women that they feel they are not doing enough. This may lend further support to some interpretations already suggested. If men do provide care by choice rather than in fulfillment of social expectations, could this contribute to a feeling of genuinely wanting to do more? An alternate, though not necessarily conflicting, interpretation may be that men are just as much prisoners of socialized roles as are women. If they are more comfortable with, prepared for, and perhaps relegated to, the performance of instrumental functions, could it be that men in caregiving roles are desirous of, but somehow unable to perform a more nurturing role? If so, this may contribute to their feeling of not doing enough.

Formal vs. Informal Caregiving Systems

Despite the overwhelming evidence of the continued interest and involvement of families in the lives of older family members, there is also evidence which suggests that families are more willing and able to perform some services and not others. As was reported earlier, the Loretto caregivers were more apt to give of their time, make frequent visits, help with money management and transportation, and provide emotional support. They were, however, less likely to provide financial support, meals, housekeeping and personal care. Other researchers report similar findings. E. Brody (1981) reports that caregiving women express the belief that formal services should provide instrumental and financial help. However, Brody reports strong intergenerational agreement that adult children should provide help with financial management and act as confidant. Monk (1979) asserts that, while families generally don't support an older member financially, they do provide essential chores and socio-emotional support. Archbold (1983) defines two separate types of caregiving roles, exploring the stresses and relationship quality characteristic of each. Women who act as managers of services being received by their chronically ill parent were able to devote more thought and attention to the

psychological and social needs of the parent, and identify more benefits related to caregiving, than were women who provided care themselves. The latter group reported much higher costs related to their caregiving role: resentment, irritation with the parent, and feeling overwhelmed by the physical tasks of caregiving.

One might reasonably conclude that families cannot possibly possess all the resources necessary to meet the complex health and social needs of an increasingly elderly population of aged family members. Planners must consider the interaction of these caregiving systems with an eye toward policy change.

Implications for Social Policy

The implications suggested by this analysis of the Loretto results occur at two levels and involve re-negotiations of the roles played by men and women and the functions of the formal and informal caregiving systems.

Between Men and Women

Despite attitude changes in recent years, it appears that, with respect to meeting the needs of older persons, men and women continue to act on traditional sex roles. The perspective presented in this analysis has suggested that this may be problematic for both sexes. Women are more likely to feel resentment, have their own health suffer, and, perhaps, perceive a lack of choice in fulfilling caregiving roles. Men express a feeling of not doing enough, which may reflect some frustration with traditional role limitations.

One approach to foster quality care of the aged and supportive family interrelationships is via policies which both facilitate the translation of attitude changes into behavioral changes and remove institutionalized barriers to that process. Some examples from the literature might serve as a springboard for this creative process. Zarit (1980) concludes, because a feeling of burden on the part of the primary caregiver is related to frequency of visits, that these caregivers are best served by interventions that involve other members of the older person's support system. Johnson (1982) reports positive results from a program developed to provide suport to adults concerned about an aging parent. In a supportive group situation, adult children were trained in communication techniques and provided information about processes of aging.

Approaches to changing behaviors based on sex roles could be two pronged. Training of professionals who work with the elderly and their families, emphasizing a thinking beyond sex-typed limitations, may be a first step. This could facilitate the recognition of patterns of professional-family interaction that presuppose of encourage sex-typed family involvements. Working with families themselves via inclusive interventions, could provide both men and women opportunities to explore their options for caregiving roles, and the skills and support to fill those roles. In these ways, sex-typed limitations in family service provision may be diminished.

Formal and Informal Support Systems

The second implication growing from this analysis is that policy makers must re-examine our societal response to the needs of older individuals for care. S. Brody (1978) asserts that, just as the national response to the need for acute care was to build hospitals, the response to the increasing need for chronic care is to buld a segregated institutional system of chronic care. Archbold (1983) points out that less that 1% of the Medicaid and Medicare budgets are spent on home-based health services. It is ironic that, while families continue to be actively involved with older members and continue to uphold the value of maintaining that active role, and while conventional ideology claims to value family involvement and deinstitutionalization, community-based services for chronically ill and disabled persons receive little attention and less reimbursement (Brody, S.,1978). The family or older person seeking an alternative to institutional care often does so in a unresponsive community, devoid of services and support. E. Brody (1981) points out that, while responses to the needs of child-care providers for support in fulfilling those responsibilities are socially acceptable (baby sitting, day care, etc...) similar responses for those providing care to older persons (day care, respite, etc...), are almost non-existant. This either-or situation undoubtedly places stress on older persons and caregiving families in the community, and may lead to institutionalization.

In addition to family involvement, we have also seen that families generally cannot meet all the needs of an older person alone, and probably meet some needs better that others. This situation will likely intensify as the proportion of older individuals in the population increases, as some members of that group become characterized by increasingly complex medical needs, and as the principle caregivers in this society, women, assume more and more responsibilities in other roles. Furthermore, as has been suggested, the role of choice must be explored as an issue

related to quality of life for older persons and families. What is needed, therefore, are broader perspectives on ways to provide care to the elderly. Policies must encompass new concepts in varied and integrated community resources, as opposed to the either-or choices of an institutionally-based system. And, these resources must be planned in a manner cognizant of family resources, actual and potential (e.g. men's potential to fulfill supportive roles). As Nelson (1982) asserts, the question is not whether government should be involved in care of the elderly, but how to do so in a manner sensitive to its implications for families. The earlier discussion of the quality of life issues with respect to Archbold's (1983) care providers vs. care managers, and our speculations that the generally positive feelings reported by the Loretto caregivers as related to the sharing of responsibilities by formal and informal systems, are examples of the kinds of considerations that need to be taken into account.

New Directions

Creative input into the translation of these perspectives into services for elderly persons may be gained by borrowing from the literature on disabled persons, another group for whom societal response to their needs has been a segregated institutionalized system. Blatt (1977) writes that the concept of deinstitutionalization defines too narrowly the change that is needed if a system of humanizing community options is to be developed. Calling such development a "Conversion Model", Blatt identifies the goal as the transformation of a segregated institutionalized model of services into a humanizing, integrated community model. Deinstitutionalization alone, without sensitivity to the needs of older persons enmeshed in family systems, and for community resources, represents an insufficient response to the poor quality of life which is often avialable both in institutions and in communities without adequate services.

One mechanism by which such change could occur deserves mention. In late 1983, the Family and Community Living Amendments Bill was introduced into Congress. Dealing specifically with services for persons with disabilities, but encompassing some of the issues discussed here with regard to older persons, this Bill would require a shift of Medicaid funds from institutions to communitybased or family provided services. Such a measure could encourage the development of creative new approaches to community services and provide funding for them. Perhaps more important is its recognition of the crucial roles played by families in the care of their own members and provision for the financial and supportive services for the continuation and expansion of this role.

It is only through such re-thinking of the roles of formal and informal systems, how they can mesh, and the re-channeling of money to more inventive, humanizing alternatives of care, that the agonizing decisions of families either to institutionalize a family member or go it alone, can be avoided. Without such change, either option often creates a deterioration in the quality of live of the families and older persons in our society.

Conclusion

This exploration into the care of elderly persons from the perspectives of formal vs. informal support systems, and roles played by men and women, has pointed to a need to re-examine and redefine our traditional patterns of service delivery. Formal services must continue to play an important role within the long-term care system, but creative, alternative approaches to providing that formal care must be explored and developed. Attention to the implications for families must accompany this process. The helping professions must also consider ways in which family support services can be deepened and broadened. In particular, facilitation of the translation of egalitarian attitudes into action will help diminish sex-typed limitations in family service provision. Both men and women should be free choose, in a supportive environment, the caregiving roles they can fulfill. The long-range impact of these new directions on the quality of life possible for older persons in need of care must, ultimately, motivate these processes.

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